STATE OF MICHIGAN

DEPARTMENT OF LABOR & ECONOMIC GROWTH

OFFICE OF FINANCIAL AND INSURANCE REGULATION

Before the Commissioner of Financial and Insurance Regulation

In the matter of

XXXXX
Petitioner **File No. 89904-001-SF**

v

Blue Cross Blue Shield of Michigan
Respondent
_____/

Issued and entered
this 25th day of July 2008
by Ken Ross
Commissioner

ORDER

I
PROCEDURAL BACKGROUND

On May 20, 2008, XXXXX (Petitioner) filed a request for external review with the Commissioner of Financial and Insurance Regulation under Public Act No. 495 of 2006 (Act 495), MCL 550.1951 *et seq*. The Commissioner reviewed the request and accepted it on May 28, 2008.

Under Section 2(2) of Act 495, MCL 550.1952(2), the Commissioner conducts this external review as though the Petitioner was a covered person under the Patient's Right to Independent Review Act, MCL 550.1901 *et seq*.

The Commissioner notified Blue Cross Blue Shield of Michigan (BCBSM) of the external review and requested the information used in making its adverse determination. The Commissioner received BCBSM's response on June 12, 2008.

As a retired State of Michigan employee, the Petitioner is enrolled for health coverage under the State Health Plan PPO, a self-funded group. BCBSM administers the plan.

The issue in this external review can be decided by a contractual analysis. The contract

involved here is the State Health Plan PPO's *Your Benefit Guide* (the guide), the document that describes the Petitioner's coverage. The Commissioner reviews contractual issues pursuant to MCL 550.1911(7). This matter does not require a medical opinion from an independent review organization.

II
FACTUAL BACKGROUND

On July 4, 2007, the Petitioner ruptured his left Achilles tendon. He had surgery on July 23, 2007, to repair the rupture. On August 5, 2007, it was found that the incision was infected and he was admitted to the hospital. He had additional surgeries because of the infection and while in the hospital he used negative pressure wound therapy (a "wound vacuum") to aid in the healing.

Before the Petitioner could leave the hospital he needed a portable wound vacuum, an item of durable medical equipment (DME). The device was provided by XXXXX. The Petitioner used the wound vacuum from August 20, 2007, until September 6, 2007. XXXXX charged $5,565.00 for the device and BCBSM initially paid $614.40.

The Petitioner appealed BCBSM's payment amount. BCBSM held a managerial-level conference on March 12, 2008, and issued a final adverse determination dated April 1, 2008.

III
ISSUE

Is BCBSM required to pay an additional amount for the equipment provided by XXXXXI?

IV
ANALYSIS

Petitioner's Argument

The Petitioner is aggrieved because BCBSM has not paid all of the bill from XXXXX for the use of the wound vacuum and supplies in August and September 2007.

According to the Petitioner, XXXXX told him that they were a participating DME provider with BCBSM and that a XXXXX representative called BCBSM when the Petitioner was in the hospital and confirmed that XXXXX was participating. At the time the Petitioner was in a hospital bed

connected to IVs and using a wound vacuum, XXXXX continued to indicate they participated with BCBSM and assured the Petitioner that things would be worked out. The Petitioner believes that he used due diligence to determine that his DME was covered.

The initial charge for the Petitioner's DME and supplies from XXXXX was $6,615, later reduced. The Petitioner believes that the bill should further be reduced when XXXXX provides documentation related to the vacuum supplies. The Petitioner wants BCBSM to pay the remaining amount due after further adjustments or thinks that XXXXX and BCBSM should agree to settle for some other amount.

BCBSM's Argument

BCBSM says that the guide clearly states that BCBSM pays its "approved amount" for covered services. The approved amount is the lesser of the provider's charge or BCBSM's maximum payment level for the service. The guide does not guarantee that charges will be paid in full.

Although XXXXX apparently told the Petitioner that it participated with BCBSM, it was not participating as of August and September 2007 when the DME was received (XXXXX ceased participation with BCBSM after April 2007). As a nonparticipating provider it is not required to accept BCBSM's approved amount as payment in full and it may bill the Petitioner for the difference between its charge and BCBSM's payment.

Further, because XXXXX was nonparticipating, BCBSM applied a sanction of 20% of its approved amount for the Petitioner's care ($153.60) as required by the guide. However, BCBSM acknowledged there was confusion about the participation status of XXXXX and so agreed to waive the out-of-network sanction and pay the Petitioner an additional $153.60. When this is done BCBSM says it will have paid its full approved amount for the DME the Petitioner received.

BCBSM also says it denied two specific items. Procedure code 6550 (dressing set for negative pressure wound therapy) was denied for August 20, 2007, because it exceeded the

quantity limit for this service, and denied again on September 6, 2007, because there was no documentation provided to show the medical necessity for the item.

The amounts charged by XXXXX and the amounts paid by BCBSM for the wound vacuum are:

Date of Service	Procedure Code	Amount Charged	Amount Paid by BCBSM	Balance
August 20, 2007	A6550	$350.00	$144.00	$206.00
August 20, 2007	A6550	$350.00	$0.00*	$350.00
August 20, 2007	A7000	$490.00	$38.40	$451.60
August 20, 2007	E2402	$4,025.00	$432.00	$3,593.00
September 6, 2007	A6550	$350.00	$0.00**	$350.00
Initial Totals		$5,565.00	$614.40	$4,950.60
Removal of Sanction			$153.60	($153.60)
Adjusted Totals		$5,565.00	$768.00	$4,797.00

* Denied; exceeded quantity limit.
** Denied; medical necessity not shown.

BCBSM contends that it has paid the appropriate amount for the Petitioner's DME and is not required to pay more.

Commissioner's Review

BCBSM established that XXXXX was a nonparticipating provider after April 2007. The Petitioner apparently relied on XXXXX assertions that it participated with BCBSM instead of confirming the fact with BCBSM. Under the terms of the Petitioner's coverage to avoid out-of-pocket costs, DME must be obtained through DMEnsion, the State Health Plan PPO's DME vendor, or from a provider that participates with BCBSM.

The guide describes how benefits are paid when services are received from a nonparticipating provider. First, BCBSM pays an "approved amount" for covered services -- it does not guarantee that provider charges will be paid in full. "Approved amount" is defined on page 80 of the guide as "the BCBSM maximum level or the provider's billed charge for the covered service, whichever is lower."

The same approved amount is paid for services from both participating and nonparticipating providers. However, the amount charged by a nonparticipating provider (XXXXXI in this case) may be significantly higher than BCBSM's maximum payment level for the service. Since nonparticipating providers have not signed agreements with BCBSM to accept its approved amount as payment in full, the Petitioner may be required to pay the difference between the provider's charge and the BCBSM approved amount.

BCBSM paid its approved amount (minus a 20% deductible) for the wound vacuum XXXXX provided to the Petitioner. BCBSM has now agreed not to apply the 20% out-of-network sanction and to pay the Petitioner an additional $153.60. When this is done, BCBSM will have paid its full approved amount for the three approved services.

BCBSM also denied two wound vacuum dressing sets, code A6550. One was denied because it was provided on the same day (August 20, 2007) as another one. The second dressing set was denied because it lacked medical documentation. BCBSM shall reprocess the claim for the second dressing set if the Petitioner submits additional documentation that establishes medical need.

V
ORDER

BCBSM's final adverse determination is upheld with the condition that it will pay an additional $153.60 to the Petitioner. BCBSM will reimburse the $153.60 to the Petitioner within 60 days and provide proof of payment to the Commissioner within seven days after payment is made. BCBSM shall also reprocess the claim for the dressing set (code A6550) on September 6, 2007, if additional documentation is submitted that establishes medical need. BCBSM is not required to cover any additional amount for the Petitioner's vacuum wound DME.

This is a final decision of an administrative agency. A person aggrieved by this Order may seek judicial review no later than 60 days from the date of this Order in the circuit court for the

county where the covered person resides or in the circuit court of Ingham County. See MCL 550.1915(1), made applicable by MCL 550.1952(2).

A copy of the petition for judicial review should be sent to the Commissioner of Financial and Insurance Regulation, Health Plans Division, Post Office Box 30220, Lansing, MI 48909-7720.